Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 8-10-01.

   b. The request was received on 8-9-02.

## II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92 (s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Contract information
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. UB-92
   c. EOBs/TWCC 62 forms/Medical audit summary
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 9-12-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 9-18-02. The response from the insurance carrier was received in the Division on 10-1-02. Based on 133.307 (i) the insurance carrier's response is timely.

3. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

## II. PARTIES' POSITIONS

1. Requestor: Letter dated 09/10/02
"(Requestor) charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by (Requestor) is at a minimum of 70% of billed charges. This is supported by a managed care contract with (healthcare plan) that is attached as Exhibit 1. This managed care contract supports (Requestor's) argument that the usual and customary charges are fair and reasonable and at the very least, 70% of the usual and customary charges is fair and reasonable. This managed care contract exhibits that (Requestor) is requesting reimbursement that is designed to ensure the quality of medical care and to achieve effective medical cost control as the managed care contract shows numerous Insurance Carrier's willingness to provide 70% reimbursement for Ambulatory Surgical Centers [sic] medical services. As a result, the reimbursement requested by (Requestor) is not in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf, as evidenced by the managed care contract attached….the treatment rendered was reasonable and necessary in accordance with the usual and customary standards of the medical community for the treatment of the compensable work-related injury and under the appropriate Treatment Guidelines."

2. Respondent: Letter dated 10-1-02
""ACCORDING TO RULE 134.401 (a) (4), NO FEE EXISTS FOR AMBULATORY SURGICAL CARE, AND SERVICES ARE TO BE PAID AT A FAIR AND REASONABLE RATE UNTIL THE ISSUANCE OF A FEE GUIDELINE…. IN DETERMINING WHAT CONSTITUTES A 'FAIR AND REASONABLE RATE' DID CONSIDER THE MEDICARE, PPO AND HMO PAYMENTS, AND REVIEWED THE COMMISSION'S OWN GUIDELINES FOR ACUTE CARE. ACUTE CARE GUIDELINES STATE THAT $1118.00 IS A VALID REIMBURSEMENT FOR A FULL DAY OF INPATIENT CARE, OR APPROXIMATELY 24 HOURS'.[sic] BY DEFINITION, OUTPATIENT OR AMBULATORY SURGICAL SERVICES ARE THOSE THAT REQUIRE LESS THAN 90 MINUTES ANESTHESIA TIME AND LESS THAT [sic] FOUR HOURS OF RECOVERY'.[sic] THIS MEANS THE PATIENT RECEIVES CARE FROM THE FACILITY FOR 1/4$^{TH}$ OF THE TIME OF BEING IN AN INPATIENT SETTING FOR A FULL DAY, AND THE FACILITY IS PAID AT THE **EQUIVALENT OF** A ONE DAY INPATIENT STAY. **THE ACUTE CARE FEE GUIDELINES WERE USED AS A CONSIDERATION IN DETERMINING REIMBURSEMENT – HOWEVER, THIS DOES NOT MEAN THAT INPATIENT GUIDELINES WERE APPLIED TO THIS SERVICE.** THE CARRIER HAS CONSISTENTLY APPLIED THIS REIMBURSEMENT RATIONALE FOR ALL A.S.C. SERVICES PROVIDED IN 2001."

## IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 8-10-01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $7,116.36 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $4,993.27 for services rendered on the date of service in dispute above.

5. The Carrier's EOBs denied any additional reimbursement as, "M – IN TEXAS, OUTPATIENT SERVICES ARE TO BE PAID AS FAIR AND REASONABLE".

6. The amount in dispute is $2,123.09 for services rendered on the date of service in dispute above.

## V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. The carrier has submitted documentation asserting that they have paid a fair and reasonable reimbursement. Respondent has submitted an explanation of their payment methodology.

Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and

4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable

reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;".

The carrier asserts that EOBs do not constitute a pattern substantiating fair and reasonable. While the carrier has indicated that it does consider Medicare, PPO and HMO payments and utilizes the Commission's own guidelines for acute care in its methodology, they have failed to meet the requirements of Rule 133.304 (i). TWCC Rule 134.401 (a) (4) indicates, ambulatory/outpatient surgical care is not covered by the Acute Care Inpatient Hospital Fee Guideline and as such cannot be utilized in determining reimbursement for an ASC. The Carrier has failed to support that their $1,118.00 reimbursement reflects a fair and reasonable reimbursement. The payment amount appears to reflect a payment equal to that reimbursed in an acute care setting. The Carrier has failed to expand on how their consideration of Medicare, PPOs and HMOs has contributed to the amount reimbursed.

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence of what is fair and reasonable. Even though the carrier has failed to expand on their methodology, as the requestor, the health care provider has the burden to provide documentation that "…discusses, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement…." pursuant to TWCC Rule 133.307 (g) (3) (D). The Provider, in order to support the fee billed, submitted a copy of a managed care contract indicating payment of 70% was expected. However, that contract is 10 years old. It does not provide current information. The Provider has not provided sufficient information that supports its fees billed represent a fair and reasonable charge. Therefore, based on the evidence available for review, the Requestor has not established entitlement to additional reimbursement.

The above Findings and Decision are hereby issued this 09th day of April 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division
LL/ll